

Metastatic Endometrial Carcinoma: Rare Cause of Extrahepatic Obstructive Jaundice

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We report a very rare case of endometrial carcinoma causing extrahepatic bile duct obstruction. Management of this case and probable mechanism of spread are presented. © 1996 Wiley-Liss, Inc.

KEY WORDS: endometrial carcinoma, jaundice, bile duct obstruction

INTRODUCTION

The liver is a frequent site of both exogenous and endogenous disorders. Jaundice is often an early indicator for the presence of hyperbilirubinemia and hepatic dysfunction. The etiologies of the latter, in the absence of trauma, are: the overproduction of bilirubin or the obstruction to the outflow of bile produced. Common practice dictates examination of the biliary tract as the primary area of dysfunction when excluding exogenous sources of jaundice. It is very rare that metastatic disease results in obstructive jaundice. Colonic carcinoma is the most commonly encountered cause of metastatic disease resulting in biliary tract obstruction [1-3]. Ovarian carcinoma is another pelvic cancer causing primary extrahepatic biliary obstruction and is similarly very unusual, with only four cases having been reported [1,4,5].

This case report represents the first occurrence of metastatic endometrial carcinoma presenting as a single metastatic focus with a clinical picture of only extrahepatic bile duct obstruction. This was confirmed at surgical exploration. Stellato et al. [5] presented a case producing the same clinical picture but with disseminated endstage intra-abdominal metastasis.

CASE REPORT

A 78-year-old female had been hospitalized in 1985 for treatment of a large ventral hernia. A pelvic examination revealed a tumor of the uterus, and the patient underwent workup including a D&C. The pathology revealed endometrial carcinoma.

The patient subsequently underwent a total abdominal hysterectomy, bilateral salpingo-oophorectomy, and a repair of a large ventral hernia. Vena cava clipping was also

performed because of a history of recurrent deep venous thrombosis and pulmonary embolism. There was no evidence of extra pelvic extension of tumor. The pathology report revealed an invasive Grade I endometrial adenocarcinoma extending through 50% of the myometrium with transmural invasion of the cervix. There was lymphatic invasion.

Four years later this patient presented with symptoms of upper gastrointestinal obstruction. CAT scan findings were consistent with gastric outlet obstruction. The patient underwent exploratory laparotomy, at which time dense adhesions were found in the area of the prior vena cava clipping and appeared to be the source of the duodenal obstruction. No pancreatic or other masses were appreciated. A gastrojejunostomy was performed and the patient again did well postoperatively.

One year later she developed an epigastric mass with painless jaundice. The admitting laboratory values were notable for a bilirubin of 19.6 and an alkaline phosphatase of 276. The CAT scan showed distal duodenal and common bile duct obstruction. The patient was re-explored after temporary percutaneous biliary drainage. She was found to have dense tumor in the paraduodenal and retroperitoneal regions. Frozen sections were positive for adenocarcinoma, and dense localized metastatic disease precluded debulking. A choledochojunostomy was performed.

The pathology of the paraduodenal and retroperitoneal masses was positive for metastatic endometrial adenocarcinoma. Review of the specimen obtained from the hys-

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terectomy performed in 1985 showed the same histologic features. The lesion of the second portion of the duodenum also showed metastatic adenocarcinoma consistent with an endometrial primary.

DISCUSSION

The true occurrence of obstructive jaundice secondary to metastatic pelvic carcinoma remains extremely rare. Metastasis occurs by either direct invasion, hematogenous spread, or lymphatic spread. The metastasis of the endometrial carcinoma in this patient is presumed to have occurred via periaortic nodes. Normal endometrium is rich in lymphatic drainage.

Uterine lymphatics drain segmentally, i.e., cervical nodes reach the bifurcation of the iliacs, whereas those from the uterine body flow to the hypogastric nodes. A second group, in conjunction with ovarian lymphatics, drain into the greater periaortic lymph node group.

CONCLUSION

Previous authors have postulated that the rarity of this clinical presentation is related to the limited expansion of the para-aortic nodes in this disease [4]. This may, however, also be a function of detection and treatment prior to the disease progressing to a point where distant nodes enlarge sufficiently to cause mechanical obstruction [4].

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